practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards, unless the respective Mental Health Act needs to be invoked.

**CONFIRMING DIAGNOSIS**
A diagnosis of bipolar disorder is supported by diagnostic criteria and usually confirmed by a psychiatrist. The individual should be monitored appropriately following diagnosis, especially after the first episode, when diagnostic uncertainty is common. Individuals may present a significant period after the condition first arises, which may make the diagnosis difficult, as insight into previous episodes may be poor.

Further complications arise from inconsistencies between diagnostic criteria. The two classification systems (DSM 57 and ICD-1011) are not identical, with differences in the number of required episodes and distinction between bipolar I and II disorders. NICE recommends that for children or young people, diagnosis of bipolar disorder should be made only after a period of intensive, longitudinal monitoring by a healthcare professional or multidisciplinary team trained and experienced in the assessment, diagnosis and management of bipolar disorder for that age group, and in collaboration with parents or carers.6 Mania and euphoria must be present for a diagnosis of bipolar disorder; irritability should be taken into account but is not a core diagnostic criterion.

Children or young people with depression and a family history of bipolar disorder should be followed up, but a diagnosis cannot be made on family history alone.

The updated guidance includes specific recommendations for diagnosis in these age groups, as the presentation of symptoms can be complicated by other conditions, such as ADHD.6

**REFERRAL**
If the GP suspects mania or severe depression, or if patients are a danger to themselves or others an urgent referral should be made for a specialist mental health assessment. If bipolar disorder is managed solely in primary care, patients should be re-referred to secondary care under any of the circumstances listed in table 2, left.

**MANAGEMENT**

**Pharmacological treatment**
Although the evidence base is rapidly expanding, the pharmacological treatment of bipolar disorder continues largely to consist of a two-drug combination approach, which includes lithium as a mood stabiliser, and acutely anti-manic and antidepressant drugs of several different drug classes. As acute antimanic treatments, olanzapine, risperidone and haloperidol are recommended.12

‘During remission patients may be more susceptible to information but less motivated to continue treatment’

The evidence base for the use of antidepressants has almost doubled since the 2006 NICE guideline was published.

Recent specific recommendations suggest combining fluoxetine with olanzapine to protect against both poles of the illness.6 Quetiapine too has empirical support as an antidepressant treatment in bipolar disorder13,15 and more recently as a maintenance treatment on a par with lithium.16 With its recent official FDA approval in the USA, the use of lurasidone as an effective and tolerable antidepressant in bipolar disorder is also gaining ground.17,18

Although its acute anti-manic efficacy remains less impressive, lithium continues to have the best evidence base for the long-term management and relapse prevention of bipolar disorder, reducing the risk of suicide by more than 50%.20 NICE recommends other drugs, such as olanzapine, quetiapine and valproate as second-line prophylactics, if there is